CHAPTER 2 — HEALTH PLAN AND PROGRAM INFORMATION

The Wisconsin Public Employers Group Health Insurance program consists of three types of plans: Alternate Health Plans, Standard Plan and State Maintenance Plan.

201 Alternate Health Plans (HMOs)

Alternate health plans are typically Health Maintenance Organizations (HMO) and provide comprehensive benefits at a lower cost than the Standard Plan in exchange for some health care provider limitations. All alternate health plans participating in the Group Health Insurance program offer the same level of coverage, called Uniform Benefits, with the exception of dental coverage that may be offered at the discretion of the health plan. Uniform Benefits are designed to ease employee health plan selection and assist ETF's efforts to negotiate quality care at the lowest possible cost. With Uniform Benefits, employees can select a health plan based on cost, quality of services, and access to specific physicians or other health care providers.

Employers can choose to offer the traditional Uniform Benefits, or Uniform Benefits with an upfront deductible on medical services that is available at a lower premium rate. (Refer to subchapter 204.)

202 Standard Plan

The Standard Plan is a self-insured plan that pools the combined claims experience of all participating local governments. The classic Standard Plan is a fee for service indemnity plan. That is, employees enrolled in the Standard Plan can see any provider of their choice and are not restricted to specific providers, as in HMOs.

Employers can choose either the Classic Standard Plan or the Standard Preferred Provider Plan (PPP) option, which is available at a lower premium rate. (Refer to subchapter 204.) The PPP option allows participants to see any provider of their choice, but with differences in benefit levels depending on whether participants go to an in-network (higher benefit level) or an out-of-network (lesser benefit level) provider.

203 State Maintenance Plan (SMP)

The State Maintenance Plan (SMP) is another self-insured plan, but is available only in those counties that do not have an alternate health plan as designated in the current *It's Your Choice* booklet (ET-2128) as qualified, i.e., meeting minimum provider availability requirements. SMP subscribers must select an affiliated clinic to manage their health care and are subject to some health care provider limitations.

204 Program Options

Effective January 1, 2005, employers participating in the Group Health Insurance program can select from several different program options. Employers must select one option for all eligible employees, annuitants (retirees), and continuants and may not split its group between the options.

- Traditional HMO option paired with the Classic Standard Plan. Employers participating in the Group Health Insurance program prior to January 1, 2005, are enrolled in this option unless they have filed a resolution selecting a different option. Under this program option, participants select from:
  - HMOs that administer traditional Uniform Benefits
  - Classic Standard Plan with a deductible and coinsurance (participant pays percentage of costs) on major medical services only, such as durable medical equipment, physical/speech/occupational therapy, medical services and supplies, and cardiac rehabilitation
  - SMP, where applicable, with a deductible and coinsurance on major medical services only

- Traditional HMO option paired with the Standard PPP. Under this program option, participants select from:
  - HMOs that administer traditional Uniform Benefits
  - Standard PPP for which the benefit level (i.e., upfront deductible and coinsurance) depends on whether the services are from an in-network provider or an out-of-network provider
  - SMP, where applicable, with a deductible and coinsurance on major medical services only

- Deductible HMO option paired with the Deductible Standard Plan. Under this program option, participants select from:
  - HMOs that administer the Uniform Benefits with an upfront deductible on all medical services
  - Deductible Standard Plan with an upfront deductible and coinsurance on all medical services
  - SMP, where applicable, with an upfront deductible on all medical services

- Deductible HMO option paired with the Deductible Standard PPP. Under this program option, participants select from:
    - HMOs that administer the Uniform Benefits with an upfront deductible on all medical services
    - Deductible Standard PPP for which the benefit level (i.e., upfront deductible and coinsurance) depends on whether the services are from an in-network provider or an out-of network provider
    - SMP, where applicable, with an upfront deductible on all medical services

Employers must file a new resolution by October 1to enroll in a different program option with an effective date of January 1 of the following year. Refer to Chapter 5 for instructions for submitting monthly reports when changing program options. Employers interested in changing their program option should contact the Employer Communication Center at (608) 264-7900.

205 Pharmacy Benefit Manager (PBM)

A Pharmacy Benefit Manager (PBM) is a third party administrator of the prescription drug program and is primarily responsible for processing and paying prescription drug claims. All Participants in the Group Health Insurance program, including local government employees and annuitants, receive their pharmacy benefits through the PBM regardless of the health plan they have chosen. The PBM allows ETF to uniformly administer pharmacy benefits for all participants.

Subscribers receive separate identification (ID) cards from the PBM and must present that ID card to their pharmacist when filling a prescription. Please contact the PBM for questions pertaining to the pharmacy benefit (e.g. drug formularies, claims, replacement ID cards, etc.) Refer to subchapter 108 for information on contacting the PBM.

206 Health Plan Contacts

Health premiums, benefits, provider networks and program policies and procedures may change annually. Such changes are communicated to employers through *Employer Bulletins* and to employees through the *It's Your Choice* booklet (ET-2128) as well as through communications from the health plans (e.g., provider listings). Contact the health plan representative directly with specific questions regarding such topics as referral policies, benefits, filing of claims, and/or provider networks. Health plan addresses and phone numbers are listed in the *It's Your Choice* booklet. A listing of *Health Plan Contacts* (ET-1728) is available online at ETF's Web site (http://etf.wi.gov) under the "Employer" section.

207 Coordination of Benefits (COB)

For a variety of reasons, some individuals are covered under more than one group health insurance plan. When this occurs, the benefits will be paid, or "coordinated,"

according to insurance regulations used to determine the order in which the plans will pay benefits. The plan that pays first is called the “primary plan” and the plan that pays next is the “secondary plan.” The insurance regulations for determining the order that plans will pay benefits are described in the *It’s Your Choice* booklet (ET-2128). Questions about COB can also be directed to health plans.